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ORIGINAL COMMUNICATIONS.

APHONIA.

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IN order to the production of a laryngeal sound, two things are necessary,—the passage of a sufficiently forcible current of air through the larynx, and a due approximation and tension of the vocal cords. The first of these conditions is supplied by the action of the chest, and is absent only when there is extreme feebleness of the expiratory muscles, or when the air escapes from the trachea below the larynx, as in tracheotomy. The second condition is much more complex, and may be interfered with in a variety of ways.

The causes of this interference and of the resulting aphonia or loss of laryngeal voice may be divided into those which act mechanically upon the larynx itself, and those which produce paralysis of the muscles of phonation.

When aphonia is due to one of the first class of causes, there exists some departure from the normal condition of the larynx, which presents a mechanical obstacle to the proper approximation and vibration of the cords. The diseased conditions which produce this effect are numerous and varied.

The most frequent is congestion of the larynx from cold. This acts in two ways: first, when the mucous membrane of the cords themselves is swollen, in which case their vibration is interfered with; and secondly, when there is tumefaction of the inter-arytenoid fold, which prevents the approximation of the arytenoid cartilages and consequently of the cords. Tumefaction of the ventricular bands also—which lie just above and parallel to the vocal cords—may cause pressure upon the latter and prevent their vibration. This is not unfrequently the case in acute laryngitis.

Another very frequent cause of aphonia is ulceration attacking either the cords or some other of the movable portions of the larynx. Ulceration of the cords alone in order to produce complete aphonia must be quite extensive. There must be sufficient loss of substance to leave a considerable opening when the cords are approximated to their fullest extent. A less degree will produce hoarseness only. But it generally happens that the same affection which has led to ulceration of the cords has involved other portions of the larynx at the same time, inducing, if not ulceration, at least tumefaction of the mucous membrane. A favorite seat for ulceration is the inter-arytenoid fold already mentioned, where it effectually prevents the folding of the membrane which takes place when the arytenoid cartilages approach each other. This results not only from the tumefaction of the membrane, but from the pain which is felt whenever the ulcer is thus folded upon itself. But the tendency to aphonia in these cases does not cease when the ulcers themselves have disappeared. In many cases these latter have left behind them an obstacle to phonation quite as formidable as they themselves constituted, in the stiff, contracted, and unyielding cicatrix. Ulcers situated at the anterior extremity of the chink of the glottis and affecting both cords are almost certain on healing to cause adhesion of their edges, analogous to the growing together of the fingers when the skin between them is destroyed by a burn. Situated posteriorly, these cicatrices may drag one or other of the cords out of its natural plane, so that when it approaches the median line it will be above or below its fellow, thus rendering phonation impossible.

Growths of various kinds within the larynx may also be so situated as to prevent a proper approach of the cords. These growths, most frequently polypi or papillomata, are often seated upon the free edge of a cord. In other instances they are just below or just above the cord, near enough to interfere with its action. At other times one of the arytenoid cartilages is the seat of the growth, which impinges against the cartilage of the opposite side before the cords come in contact. In a case which presented itself to me a few weeks ago in the throat clinic at the Manhattan Eye and Ear Hospital, the right capitulum Santorini had assumed the form of a large cuboidal mass, which occupied nearly the whole of the inter-arytenoid space. In this case there had been complete aphonia for a number of years.

Aphonia is also one of the characteristics of that formidable disease—œdema of the glottis. This is in reality a misnomer, for the œdema is not of the glottis, but situated at a considerable distance above it, in the ary-epiglottidean folds. These loose folds of mucous membrane become enormously distended by effused serum, forming large tumors not very unlike sessile mucous polypi. These fall together in the median line, obstructing the ingress of air into the larynx, and of course at the same time destroying the laryngeal character of the voice.

Cases sometimes occur in which anchylosis of the crico-arytenoid articulation prevents the movement of the arytenoid cartilage, rendering impossible a proper approximation of the cords.

Such are the chief causes which, acting upon the larynx itself, present a mechanical obstacle to the formation of the voice.

The treatment of this mechanical form of aphonia is as various as the cause; but in all cases it has for its object the removal of the obstacle to the necessary closure of the glottis.

Simple tumefaction of the mucous membrane from acute or subacute inflammation may be treated by astringent applications with a brush or sponge. Of these the sulphates of copper and zinc, alum, and the perchloride and the sulphate of iron, are especially useful applied in solution. The nitrate of silver has the disadvantage of causing excessive spasm, and, as in most cases equally good effects can be obtained with other applications not open to this objection, it would be better if its use were

reserved for exceptional cases. In the form of spray, however, it is more easily borne, and often produces excellent results. It requires to be used in a very strong solution, sometimes as high as 240 grains to the ounce, and should be thrown directly upon the part.

Much benefit is often derived in these cases from the inhalation of steam containing some soothing medicament. A favorite prescription of Dr. Mackenzie, of London, and one which I have found of great service, is the compound tincture of benzoin. A teaspoonful of this is put into a pint of hot water in a narrow-mouthed pitcher, and the steam is inhaled as long as it continues to come off. When the inflammation is of a more chronic character, inhalations of the stimulating essential oils may be resorted to with benefit. Non-volatile substances, stimulant or astringent, may be nebulized by means of the steam or air atomizers now in such general use.

When the brush is used, I think it well to have the solutions made with glycerin, inasmuch as from its adhesive quality it remains longer in contact with the part, while at the same time its affinity for water makes it a valuable local depletant.

When the inflammation results in œdema of the larynx, scarification after the manner first brought into use by Dr. Buck is the only measure which offers any certainty of relief. As originally performed by Dr. Buck, the operation consists in carrying a curved knife down to the seat of the œdema, using the index finger of the left hand as a guide, and making several scarifications so as to afford a free exit for the serum. Since the introduction of the laryngoscope the mirror has been used to guide the instrument.

Various instruments have also been devised having concealed blades, which are designed to facilitate the operation and render it safer.

The following case illustrates so well the nature of the affection, and also the result of this treatment, that, although the aphonia was a subordinate element in the case, the reader will pardon a momentary digression in relating it.

James Keegan, Ireland, æt. 32, soldier, during the winter of 1861–62 was under my care while lying in camp opposite Washington. He had for months been the subject of syphilitic inflammation of the larynx, and his condition was such that I anticipated the occurrence of œdema at any time when he should be subjected to unusual exposure. One night I was awakened by a strange crowing sound outside my tent, accompanied by a shuffling of feet, and in a moment two men entered, supporting Keegan between them. On striking a light I found him unable to stand alone, his face livid, inspiration exceedingly difficult and accompanied by a loud whoop. He could whisper a few words at a time, but his mind appeared to be wandering. The examination of the throat with the finger was very much facilitated by the frequent manipulations to which it had been subjected in previous treatment. He had acquired the power of opening the mouth to an extent which permitted the introduction of a part of the hand as well as the finger, and the throat had become so accustomed to the contact of foreign bodies that it could bear any amount of touching without exciting reflex action. These conditions made it very easy to carry the finger down to the larynx and thoroughly examine the parts. The ary-epiglottic folds were found to be enormously distended with serum, the tumors being of the size and shape of small chestnuts. I took a long curved sharp-pointed bistoury and covered the blade with adhesive plaster to within half an inch of the point. Then, using the left index finger as a guide, I had no difficulty in making several thrusts into the œdematous mass. This was followed by the expectoration of a little blood mixed with saliva and serum. The dyspnœa very soon became less urgent, and within an hour the patient was entirely relieved. A few days afterwards the army was transferred to the Peninsula, and Keegan was sent to a general hospital, together with a statement of his case. Soon after I received a piteous letter from him, begging to be returned to the regiment, stating that he had had two attacks of choking less severe than the first one, and that the doctors at the hospital did not know how to relieve him. He added that he was certain he should choke to death sometime if I did not have him returned to my care. This was of course impossible, and a month later I had the pain of learning that poor Keegan's prediction had been accurately fulfilled, he having suffocated in another attack of œdema.

The aphonia which results from loss of substance of the vocal cords is irremediable, but still it sometimes happens that approximation will finally be effected more or less perfectly by a modification of the natural movements of the parts, so that the aphonia will be remedied to a considerable extent.

When the mobility of the cords is restricted by adhesions or by the contraction of cicatrices, the parts may be divided by a cutting operation; but the tendency to heal again in the same way is such as to leave little prospect of ultimate success.

Morbid growths, if not of a malignant character, may generally be removed by evulsion, excision, caustics, or the galvanic cautery. Mucous polypi and papillomata are most readily removed by evulsion with the forceps. A great variety of instruments have been devised for this purpose, which the limits of this paper will not permit me to describe. Harder growths require cutting instruments or the use of caustics or the galvanic cautery. If pedunculated, they may sometimes be removed by means of the laryngeal écraseur.

There is another form of organic aphonia, in which there is no change of form in any of the parts of the larynx, but a paralysis of one or more of the muscles of phonation, owing either to a diseased condition of the muscle itself or to a lesion of the nerves or nerve-centres with which it is related.

The muscles of the larynx are liable to become infiltrated with the products of inflammation; the inflammation arising either in the muscle itself, or, as is more frequently the case, having its origin in the contiguous mucous membrane.

The thyro-arytenoids, lying as they do within a

fold of mucous membrane, we should expect would be more likely to be affected as the result of mucous inflammation than the other muscles of phonation, which are separated by intervening cartilage from any mucous surface; and I have within the present week seen a case of acute laryngitis in which these muscles were paralyzed, causing complete aphonia.

The paralysis of the muscle in such cases will usually disappear as the effused material is absorbed. In some cases, however, this condition is followed by fatty atrophy of the muscular fibre, in which case the paralysis is of course permanent. In other cases a purely functional paralysis remains for some time after the inflammation has disappeared, as will be noticed more fully in another connection.

Paralysis of the muscles may also result from syphilis, diphtheria, lead- or arsenic-poisoning, etc.

The larynx seems, moreover, to be peculiarly susceptible to the influence of irritation in distant parts in which its nerves are not directly implicated, or, in other words, to reflex paralysis, just as we find paraplegia resulting from stricture of the urethra or from the irritation of worms in the alimentary canal. So we may find paralysis of one or more of the laryngeal muscles dependent upon irritation of the abdominal or pelvic viscera. In fact, there is a form of aphonia which derives its appellation from its frequent association with derangements of the uterine function, viz., hysterical aphonia.

But a very frequent source of these paralyses is to be found in an interference with the nervous supply from some cause external to the larynx. This may be a growth pressing upon the recurrent nerve, or the irritation of this nerve produced by tubercular deposit in the apex of the lung, especially the right.

Again, the paralysis may be caused by disease in the medulla at the origin of the pneumogastric nerve, in which case it will be associated with paralysis of other parts.

There is also another form of paralysis which has no appreciable lesion whatever to account for it, and which gives rise to what is known as functional aphonia.

Whatever the source of the paralysis, aphonia, more or less complete, will be the result whenever the vocal cords cannot be brought together and the proper degree of tension maintained.

The muscles of the larynx may be affected singly or in pairs, and thus we have unilateral and bilateral paralysis of the adductors.

Unilateral paralysis of the adductors is very generally due to some cause located outside of the larynx and affecting the recurrent nerve. This may be a tumor in the track of the nerve, as an aneurism, a goitre, a malignant growth, etc. When this condition occurs on the *left* side, it at once excites suspicion of aneurism of the arch of the aorta at the point where the left recurrent nerve is looped around the vessel.

Occurring on the right side, it is often attributable, according to Mandl, to irritation of the recurrent nerve by the pressure of tubercle in the apex of the lung, the nerve on the right side being in close relation to the pleura. He found the voice affected in fifty out of fifty-two cases in which the right apex alone was diseased, and in only one out of thirty-two involving the left.

Mackenzie's experience, however, goes to disprove this theory. He found that of seven cases of paralysis of one cord in phthisical subjects six were on the left side.

The poison of lead or arsenic, and also of syphilis and diphtheria, may be confined in its action to one side of the larynx, though its effect is more likely to be symmetrical. The same may be said of disease at the origin of the pneumogastric nerve.

In unilateral paralysis the laryngoscopic appearances are striking and characteristic. When phonation is attempted, one cord is seen to advance to the median line, or perhaps beyond it, while the other remains stationary. Very commonly the paralyzed cord is somewhat congested.

Aphonia does not always result from paralysis of one cord, as the other sometimes moves far enough beyond the median line to meet its paralyzed fellow.

(To be continued.)

THE EXTERNAL EAR A SYNTHETIC RESONATOR.

BY CHARLES H. BURNETT, M.D.,

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THE auricle, or ear of common language, has usually received but little attention from physiologists. In most cases it is passed by with the vague statement that it serves "to collect sound," or that it exercises "little or no influence upon hearing." The external ear does indeed collect sound, for its function is that of a *synthetic resonator*. It therefore exercises great influence upon hearing, since it insures the proper reception by the auditory nerve of the partial tones composing many sounds produced both by nature and by art.

Before any further explanation of the functions of the auricle, let us briefly consider the acoustic nature of some of the ordinary sounds which are received by it. It is well known that every sound is composed of a collection of "partial tones" or "over-tones" which determine its timbre or clang-tint. Any one of the ordinary sounds of nature, as, for example, the roar of a cataract or of the surf, and the rustling of the leaves in a forest, is composed of a large number of partial tones, which, for the sake of simplicity, let us call deep, intermediate, and high partial tones.

The ordinary normal ear does not isolate any of the partial tones of a composite sound, but perceives them as a whole.

This is due to the fact that certain parts of the auricle resound best to the high partial tones, while other portions of it resound best to the intermediate and low partial tones, thus insuring the complete reception by the auditory nerve of all the partial tones which compose any given sound falling on the auricle. I have discovered by experiments upon my own ear that the region of the helix and its fossa resound to the deeper notes, the antihelix and its fossa to the intermediate notes, and that the concha,

"the deep concavity within the position of the antihelix, presenting a semi-spiral course towards the entrance of the auditory meatus," resounds best to the high partial tones. In order to prove this it is necessary to be in the presence of a sound possessing the characteristics of those already mentioned. By pressing the auricle at its outer edge gently forward, the sound instantly becomes a deeper one, from the augmentation of the resonance for deep tones thus gained by the helix and its fossa.

The deep tones, however, are immediately weakened or lost by placing the finger upon the helix and pressing it firmly against the head. Then we find that the sound becomes one in which the intermediate and higher partial tones are prominent. By pressure upon the antihelix the intermediate tones become weaker, and the higher partial tones are most distinctly perceived, on account of their undisturbed resonance in the concha. Firm pressure upon the helix, antihelix, and concha will interfere with the resonance of all but the highest partial tones. In the latter instance the resonance of the meatus auditorius externus most probably has full scope, for this part of the ear, according to Helmholtz, resounds best to notes of the fourth octave (e^{iv}–g^{iv}). Therefore, if any one of these portions of the auricle has its acoustic functions altered, either by disease or artificially, the tones to which it resounds will be weakened or lost, and the prominence of the other partial tones will change the timbre of the original sound.

Experiment will show that by giving prominence to a certain portion of the auricle, viz., the helix and its fossa, a sound may be rendered fuller, and hence louder, from the increased resonance of the deeper notes which enter into its composition. This may explain the asserted increase of hearing in some cases of othæmatoma, when the swelling may have rendered these particular parts prominent and thus have increased their resonating power. But if the disease advances and produces swelling and rigidity of the entire auricle, as it usually does, we can also readily understand the cause of impairment in hearing in these cases.

A man without an auricle can indeed hear sounds, but they are altogether different, acoustically considered, from the complete sounds as heard by the possessor of the normal auricle. In the former case, a large number of the partial tones being lost, the clang-tint of the sound is altered; whereas, in the latter case, when the auricle receives and conveys synthetically all the partial tones to the auditory nerve, the timbre of the composite sound is fully perceived.

NOTE ON A SOLUTION OF IODOFORM.

BY LOUIS ELSBERG, M.D.,

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A GREAT objection to the employment of iodoform (C_2HI_3) in substance is its bad odor, which is very penetrating and persistent; furthermore, there has not hitherto been in use any effective solution for topical applications in cases where ointments are inapplicable. It will doubtless be of interest to all who know the medicinal value of iodoform to learn that both these objections have been overcome. I have found an ethereal solution which deodorizes iodoform, the solution smelling of ether only, and at the same time constitutes an effective topical remedy for diseased mucous membranes, as of the throat, nose, mouth, larynx, vagina, rectum, etc. Rhighini used an ethereal solution for direct inhalation, and Dr. Sass used an ethereal solution and also a mixture of iodoform and sweet-almond oil by means of a spray-producer for inhalation. Dr. Gubler requested Messrs. Odin and Leymarie to ascertain the relative proportions in which iodoform is soluble in ether, and the most favorable conditions for its preparation; their experiments and conclusions are published in the *Pharmaceutical Journal*, August 2, 1873. The London *Doctor* for September 1 tells us that experiments were made with pure ether of 65° Baumé (specific gravity .724), and also with ether of 62° Baumé and 56° Baumé, the temperature being 13° C. Eight grains of tincture obtained with these ethers contained iodoform in solution, respectively, to the following extent:

Ether of 65° Baumé, 1.61 grammes.
" 62° " 1.26 "
" 56° " 1.13 "

The conclusions drawn by the authors from their experiments are,—

1. To employ iodoform in the crystalline state.
2. To make the solution in a *red* glass flask by simple agitation.
3. To use the following proportions:
   Crystallized iodoform, 1 gramme;
   Ether (60° Baumé), 4 grammes.

I had a solution prepared with Squibb's ether, and find that it possesses all the advantages of iodoform in powder for local applications, without its disadvantages. The smarting which the ether may be expected to produce upon the mucous membrane is momentary only, so that the application becomes really painless. Its beneficial effects surpass my expectations.

NOTES OF HOSPITAL PRACTICE.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROF. S. D. GROSS, M.D.

Reported by J. B. Roberts.

MYOTOMY IN A CASE OF TORTICOLLIS.

A. M., æt. 7, comes before us with wry neck, caused by contraction and rigidity of the right sterno-mastoid muscle. The head is bent to the right and the face turned to the left, which, from the insertion of this muscle behind the axis of rotation of the head, must always be the result of any shortening of its fibres.

The mother states that the child was born with her head in this distorted condition; but, as cases of congenital torticollis are unusual, we do not receive this statement implicitly.

A strong tense cord is seen extending along the neck,

holding the head firmly in its abnormal position. This is the border of the contracted and indurated muscle, as can be readily proved by tracing it out with the finger.

In this case the employment of extending apparatus for the purpose of remedying the deformity would be of no avail; the only treatment at all practicable is myotomy, or division of the contracted muscular fibres. This operation, as in tenotomy for the cure of club-foot, is done subcutaneously, in order that the air may be excluded and the supervention of a high grade of inflammation prevented. The head of the patient is held by an assistant in that position which will place the muscle on the stretch and make it stand out prominently above the other cervical structures. A delicate knife or tenotome is then introduced at the outer border of the muscle, some distance above its origin, and passed flatwise under it; when the instrument has been carried across, the cutting edge is turned up against the belly of the muscle, which is severed by a sort of sawing motion. Inasmuch as the sterno-mastoid is in relation with important vessels and nerves, the surgeon must be on his guard lest he wound them. With ordinary care, however, he can perform this operation without any danger to these structures.

The rigid fibres, as soon as they have been cut, spring apart, leaving an interval between the ends. Into this space lymph will be poured out, and will finally become converted into analogous tissue, constituting between the two sections of muscle a firm uniting band.

The puncture in the integument shall be covered with adhesive plaster, but there is no subsequent treatment required except rest for a few days in bed. Occasionally it is necessary to use some mechanical contrivance after the operation to keep the head straight until the divided muscle reunites; but here we shall dispense with it, unless we find that from habit the girl continues to carry her head so to one side as to endanger the success of the operation.

LITHOTOMY IN A CHILD THREE YEARS OF AGE.

This boy, aged 3 years, has been suffering from symptoms of vesical calculus for the past year, and when he presented himself at the clinic a few days ago had severe neuralgic pains in the bladder; but this trouble has been relieved by the administration of quinine and anodynes.

Upon sounding I readily detect a stone, and shall accordingly proceed to extract it by the lateral operation devised by Cheselden, which method I consider preferable to all others. Before the performance of lithotomy, it is necessary that the patient's rectum be unloaded, so that the bowel may not be wounded by the incision; and it is also important that the bladder contain six or eight ounces of water, to distend and so protect its walls, and to facilitate the removal of the calculus.

Having placed the patient on his back, with the breech brought to the edge of the table, I introduce the staff, which, inclined a little to the right if I cut on the left side, is hooked well up under the symphysis of the pubes, and held firmly by an assistant. In the operation an incision is made through the skin, superficial fascia, and some fibres of the levator ani, and then the transverse perineal muscle, the triangular ligament, the membranous urethra, the prostate gland, and the neck of the bladder are successively divided. The external incision is begun at the raphé, an inch and a quarter above the anus, and extends obliquely to the left, about midway between the rectum and the tuberosity of the ischium, for a distance of two and a half to three inches.

In this child so large an incision is unnecessary, and I shall accordingly make it about an inch and a half in length. Placing my finger in the wound for a guide, I cut through the tissues mentioned down to the membranous urethra, where I can feel the groove in the staff. After dividing this portion of the urethra I should, in ordinary cases, place the point of the knife in the groove, and push it onward, cutting through the prostate gland and the neck of the bladder; but here I shall merely nick the prostate, and then lacerate it with my finger, so as to have as little hemorrhage as possible, and to lessen the chances of injuring the pelvic fascia. When about to make this cut, I push the rectum to the right with my finger, which has been in the wound all the time, to preclude any chance of injuring the intestine by my knife.

The transverse perineal artery is necessarily divided, but the hemorrhage can be readily controlled. Division of the artery of the bulb, however, is, from the great difficulty experienced in ligating that vessel, a serious complication, which should be carefully avoided.

As soon as the bladder is opened, the urine is expelled with a gush, which generally forces the stone down to the opening, so that it can be seized with the forceps and extracted by gentle traction and rotation. Occasionally the stone gets up behind the pubic symphysis, and can only be dislodged by external pressure over the hypogastrium; at other times, especially when enlargement of the prostate exists, it falls into the cul-de-sac behind that gland, and its seizure is rendered quite difficult.

In this instance the calculus is small, and so soft that it crumbles under the pressure of the forceps; but by using the lithotomy scoop, and washing the bladder out with water from a syringe, I succeed in removing all the particles.

After this operation the urine is usually retained for several hours, when, having accumulated to some extent, it pushes away the clots and forces its way out from the wound with a gush; but its flow is soon checked by the swelling of the parts, and it is compelled to escape by the urethra. In a day or so, however, the tumefaction subsides sufficiently to allow it to pass from the perineal incision, which is its course until the thirteenth or fourteenth day, when it again escapes by the natural channel.

The after-treatment is very simple, and consists in locking up the bowels for several days, and placing the patient on the antiphlogistic regimen.

It is exceedingly uncommon to have union by the first intention after lithotomy, but it does occasionally happen, as is shown by a case that occurred in the practice of Dr. S. W. Gross, where the wound cicatrized without the supervention of the granulating process.

PENNSYLVANIA HOSPITAL.

SERVICE OF DR. R. J. LEVIS.

Reported by JOHN B. ROBERTS.

PIROGOFF AMPUTATION AT THE ANKLE—USE OF CARBOLIZED CATGUT LIGATURES.

A MAN was brought to the hospital with his right foot crushed up to near the ankle-joint by the passage of a railroad-train over it. The whole anterior portion of the foot was so mashed that there was no resort but amputation; the only question was as to how much should be removed.

In the surgery of the hand and foot, conservation of the parts should always be an object of the operator, that he may save to the patient all possible utility of the member. The injury here, however, was too extensive to admit of either the tarso-metatarsal (Lisfranc) or the medio-tarsal (Chopart) operation, and therefore the choice was between the tibio-tarsal operations after the

methods of Pirogoff and Syme. The method of Pirogoff, which is a sort of osteoplastic operation, leaves the posterior part of the calcaneum in the flap, to be finally brought into apposition with the lower end of the tibia.

In order to save blood, the tourniquet was applied, not upon the femoral artery in Scarpa's triangle, but near to the injury, so that as little as possible of the limb might be congested by the pressure. An incision was made from the internal malleolus directly around the sole of the foot to the external malleolus, dividing the tissues down to the bone. After the tissues had been pressed backwards as much as possible, the calcaneum was sawed in a direction obliquely upwards and backwards, so that the saw traversed the bone posteriorly to the process called the sustentaculum tali.

Dr. Levis prefers to saw the bone thus, before making the anterior flap and disarticulating the astragalus, because it is firmly held by ligamentous attachments and the saw can be directed with greater accuracy.

The next procedure was to make a slightly-curved dorsal incision, which, beginning at the same point as the plantar, passed across the foot half an inch below the line of the ankle-joint, ending at the external malleolus. Then the joint was entered, the ligaments holding the astragalus to the bones of the leg divided, and the whole of the foot except the heel removed.

Great care was exercised to avoid injuring the posterior tibial artery, for if it had been pierced the flap containing the calcaneum would probably have sloughed. This unfortunate complication can be avoided in most cases by the exercise of caution; though occasionally the extent of injury necessitates the division of the vessel in order to get behind the crushed and lacerated tissues.

After the flaps had been made, a very thin section of the articulating surfaces of the tibia and fibula was sawed off, and the calcaneum brought up into apposition with the freshened bony surface. As there was too much strain upon the flaps, a thin piece was shaved off the tibia a little more obliquely, until the parts came together accurately and without tension.

In arresting hemorrhage, carbolized catgut ligatures were used, as they can be cut off short and left permanently enclosed in the wound; for their animal composition and their antiseptic properties render their presence tolerable to the tissues. These ligatures are made by soaking catgut in a solution consisting of one part of carbolic acid and four parts of olive oil, and are kept immersed until required, that they may be pliable when used. They are preferable to ordinary silk ligatures, which act as setons, preventing the healing of the wound until they are loosened by ulceration. Carbolized catgut is also recommended in ligation of arteries in continuity, because the superficial incisions may be immediately closed, so that immediate union can take place before the artery is cut through by the ligature; then, if a firm clot have not formed, secondary hemorrhage will probably be prevented, and nothing more than a sort of temporary false aneurism result.

The parts were brought together by sutures of silver wire, and adhesive strips were applied over the stump to overcome the action of the tendo Achillis, which sometimes has a tendency to draw the heel upwards, tilting the cicatrix downwards. It occasionally becomes necessary to resort to tenotomy to prevent this occurrence; but it was not required in the present instance.

The great advantages of this amputation over that through the ankle-joint (Syme) are the greater length of the leg, and the retention of the lower surface of the calcaneum and the dense cellular and fatty cushion of the heel, which allows the patient to walk directly upon the stump. The essential difference between these two methods of amputating at the ankle is the removal of the calcaneum by dissecting it entirely out of the heel flap, in Syme's operation, and the retention of an oblique section of the bone, in Pirogoff's modification.

Pirogoff's method is the more conservative procedure, as it leaves the leg at least an inch and a half longer than it can possibly be after the operation of Syme. In the former, moreover, the tendo Achillis is not cut off and the power of the limb diminished, the heel flap is not cup-like and liable to retain pus, and its vascularity is not injured by dissecting out the bone. The retention of the bone in the flap, with its natural covering of a cushion of integument, produces eventually the most perfect basis for the support of the weight of the body.

This amputation is therefore more generally applicable to cases of injury; but in amputation for chronic disease of the tarsal bones, from the liability of the cancellated texture of the calcaneum to become carious, the entire removal of the bone, as in Syme's method, is usually the more available procedure.

BELLEVUE HOSPITAL, NEW YORK.

POPLITEAL ANEURISM.

J. P., æt. 26, waiter, colored, admitted August 6, 1873, had syphilis eight years ago; with this exception, has always enjoyed good health. Three months ago, patient fell through a hatchway, injuring his back and right leg. Two weeks later, he noticed a feeling of weariness in the right leg and a dull aching pain in the popliteal space. Shortly afterwards he noticed a swelling in this space, of the size of a cherry. This tumor gradually enlarged its growth, causing increased pain down the limb.

On admission, patient is a stout and apparently healthy man. On examination, a pulsating tumor is found in the right popliteal space, of the size of an orange. The pulsation is distensile in character and synchronous with the radial pulse. A double bruit is heard in the tumor. Firm pressure on the femoral artery as it passes beneath Poupart's ligament causes diminution in size of the tumor and cessation of pulsation and bruit; but these return immediately when the pressure is removed. Measurement of the right knee exceeds that of the left by $3\frac{1}{8}$ inches. Digital compression on the femoral as it passes beneath Poupart's ligament was employed, with few intermissions, until August 21, with no apparent benefit. At ten P.M. a shot-bag of ten pounds' weight was placed over the artery, in Scarpa's triangle, assisted by digital pressure. By this means pulsation, etc., entirely ceased in the tumor, and it did not reappear when pressure was removed at the end of ten hours. Repeated examinations failed to detect the slightest pulsation, the tumor remaining firm and solid. Slight pressure was kept up for several days by means of the shot-bag. This continued pressure was well borne by the patient, who said that he experienced very little actual pain.

September 15.—Patient is to-day allowed to sit up out of bed. The tumor is as solid as on the day pressure was discontinued. The leg, which during the time compression was used was cold and required the application of external warmth, has since then resumed its natural temperature. No internal medication was employed.

A case of diffused popliteal aneurism in another ward was treated on essentially the same plan, but with no benefit up to the present.

PELVIC HÆMATOCELE.

A case of extensive effusion of blood in the pelvis, forming a tumor which occupied the hypogastric and iliac regions and extended quite up to the umbilicus,

has been treated by the inunction of equal parts of unguent. belladonnæ and glycerin, hop poultices being applied over this. The relief to pain was marked, and the tumor rapidly softened and disappeared. Internally, iron was given, and an occasional anodyne.

ASPIRATION IN RETENTION.

The following are the notes of two cases in which aspiration was employed to relieve over-distention of the bladder in retention.

Case I.—G. B., æt. 13, three days before admission, slipped from an iron railing on which he was standing, striking on the perineum. He experienced acute pain in this locality, and, shortly afterwards, on attempting to urinate found himself unable to do so. His family physician failed on attempting to introduce a catheter. On admission, patient says that he has not passed water in two days; is suffering very acutely from abdominal pain and desire to micturate; bladder enormously distended, extending above the umbilicus. Perineum red, swollen, and painful. Catheter meets obstruction five inches from the meatus. Dieulafoy's pneumatic aspirator being obtained, a small-sized trocar is introduced in the median line of the abdomen, an inch above the pubes, and a large quantity of urine withdrawn, some being left in the bladder, for fear of hemorrhagic cystitis, which is apt to arise if the bladder be too suddenly relieved of its contents. External perineal urethrotomy was performed, and an extensive rupture of the urethra found at the membranous portion. An incision was made in the wall of the canal anteriorly and posteriorly to the point of rupture. Two months after the operation, the perineal wound had closed, and a No. 10 sound passed without difficulty into the bladder.

Case II.—J. W., æt. 18. Patient states that he had gonorrhœa two years ago. Within last two weeks has had considerable difficulty in passing his water. On the morning of the day of admission he was seized with retention, and when admitted, late in the evening, had not urinated in twenty-four hours. On admission, patient is suffering acutely from constant desire to urinate. A catheter is introduced, passing a slight stricture at the meatus, and meeting obstruction three inches from the meatus at a second stricture. Efforts to pass through this failed, and, the patient suffering greatly, the aspirator was employed to relieve him.

Steurer's modification of Dieulafoy's instrument was used, and a large quantity of urine withdrawn, the point of puncture being as in Case I., the patient experiencing immediate relief, unmindful of the slight pain caused by the puncture. A whalebone guide was passed the next day, and forcible dilatation made.

ACUTE ARTICULAR RHEUMATISM.

The alkaline treatment is the one most generally adopted in the medical wards. A prescription which has found great favor is as follows:

℞ Sodæ bicarb., ʒjss;
Potass. acetat., ʒss;
Liq. ammon. acetat., fʒiij;
Aquæ, q. s. ad Oj. M.

℞ Acid. citric., ʒij;
Aquæ, Oj. M.

ʒij of each q. 3 vel 4 h.

This forms an agreeable effervescing mixture, rendering the urine alkaline very quickly. The frequency with which it is given depends upon the degree of alkalinity obtained as tested morning and evening.

On another division an effervescing draught is made without the addition of the salts of potassa. As a local application, tincture of iodine is sometimes employed. By some the painting is limited to the integument immediately over the joint; by others, the integument corresponding to the blood-supply of the joint, a broad band above and below the joint answering this purpose very well.

Usually, however, cotton dusted with potass. nitrat. and covered by oiled muslin is applied to the joints, affording marked relief. An opiate is given at night:

℞ Sol. morph. sulph. (Mag.), ♏lxxx;
Tr. belladonnæ, ♏xvj;
Aq. fœniculi, ʒij. M.
Sig. ʒj p. r. n.

If a friction-murmur develop in the pericardium or pleura, an attempt is made to arrest the inflammatory process by vesication, collodion cum cantharide being used for this purpose. If, however, this fails, hot fomentations are applied to the affected side. Spongiopiline wrung out in hot water and covered with oil silk is generally used. A young girl developed acute pleuritis, left side, and pericarditis, in the course of an attack of rheumatic fever. Spongio-piline applications to the side, changed every two hours, relieved wonderfully the intense lancinating pain she experienced, and appeared to hasten the absorption of the effused fluid. Alkalies were not used in this case. Tr. aconit. rad., ♏j q. 1 h., was given, modifying the amount of febrile disturbance. The patient rapidly convalesced.

In subacute rheumatism, iron, quinine, and cod-liver oil are given internally, with nutritious diet. Occasional revulsives, as tincture of iodine, are applied, as in the acute disease.

In chronic rheumatism, in addition to tonics, a large number of cases have been treated by painting the joint with hydrarg. et morph. oleatis, most of them receiving considerable benefit from its use, especially in the alleviation of pain.

W. H. FARRINGTON, M.D.

TRANSLATIONS.

UNILATERAL PULMONARY APOPLEXY IN RELATION TO CEREBRAL HEMORRHAGE.

By DR. AUGUSTE OLLIVIER. Translated from *Archives Générales de Médecine*, August, 1873,

BY ENRIQUE M. ESTRAZULAS, M.D.

IN the year 1866, while chief of the clinic of Prof. Grissolle, I was struck by a fact that greatly excited my attention. It was the case of a hemiplegic patient who died, and at whose post-mortem a hemorrhagic clot was found in the cerebrum, with apoplexy of the lung of the paralyzed side, that is, of the side opposed to the cerebral lesion. I then asked myself if there was not a bond of union between these two anatomical lesions, and purposed investigating the subject in future. After two years in charge of the retreat at Ivry, I have had occasion to verify the fact several times, and in the observations reported I have not referred to cases where the pulmonary apoplexy could have been traced to cardiac complication.

True pulmonary apoplexy as it is found in cardiac affections has been almost completely unnoticed by clinical observers, and no mention of it is made even in the latest works on pathology nor in special treatises.

Observation I.—Apoplexy followed by complete paralysis of motility on the right side of the face; complete paralysis of motility of the limbs of that side, and great diminution of sensibility in all the right half of the body. Dulness on percussion on the right lung,

and marked diminution of the respiratory murmur. Intense redness of right half of face shortly before death.

Post-mortem.—Cranium.—Vessels of the pia mater full of black blood. The cerebral convolutions offer nothing particular exteriorly, but on section the left corpus striatum is found torn from before backward, containing a clot as large as a nut. Blood has been effused in the corresponding lateral ventricle, which contains about two teaspoonfuls of liquid and black blood, and also a smaller quantity in the fourth ventricle.

Thorax.—Right lung adherent to the thoracic walls, and the seat of intense congestion. On section three apoplectic centres are found as large as a nut, also some emphysema; other organs offer nothing remarkable.

Three peculiarities were offered in this case: 1. Redness of right half of the face shortly before death.

2. Elevation of temperature noted in the right axilla.

3. Congestion and apoplexy limited to the lung in the paralyzed side.

Observation II.—Old hemiplegia of right side; new attack of apoplexy, with aggravation of the paralytic symptoms; paralysis of the right side of the face; paralysis of the limbs on the corresponding side, with contraction of the fingers and forearm; sensibility in the paralyzed side is diminished. Death forty-eight hours after the attack.

Post-mortem.—Cranium.—Left corpus striatum torn by apoplexy, and blood effused in the corresponding lateral ventricle, which is found full; right lung congested in all its extent, and underneath the pleura several ecchymoses of variable dimensions are found, and an apoplectic centre as large as a hazel-nut; left lung congested in its inferior and posterior third; other organs healthy.

Observation III.—Several attacks of apoplexy, aphasia and hemiplegia of right side. Death in convulsions.

Post-mortem.—Cranium.—On section of the hairy skin the vessels issue a large quantity of black blood. The bones of the cranium are very thick; the groove of the middle meningeal artery is much deeper and wider on the left side; dura mater free from adhesions, its vessels are gorged with blood and appear in varicose arborescences, its color is darkish and almost ecchymotic on the left side; on the posterior part of its left side is a fluctuating elevation, and when incised a sac is found containing about three hundred grammes of dark blood.

This hæmatoma rested on the occipital and parietal faces of the cerebrum, and extended to the fissure of Sylvius. Its walls were easily detached from the dura mater on one side, and from the arachnoid and dura mater on the other. The walls were highly vascular, with a thickness of two millimetres, and their internal surface presented a reticulated appearance. The hemisphere beneath is flattened, and the convolutions effaced. On section the gray substance is found deeper in color than on the other side. The left ventricle has no liquid.

Thorax.—Right lung adherent by old fibrous bands, crepitates badly. Its tissue is dense, and on section it presents a diffused hemorrhagic infiltration, and is studded with numerous apoplectic nuclei of variable size, situated principally in the posterior half. Other organs healthy, except the right knee, which contains some serum, and the cartilage of the patella is found eroded.

Section I.—It results from these observations that, under the influence of cerebral hemorrhage, congestion more or less intense, bloody effusions below the pleura, and true pulmonary apoplexy can be developed. This apoplexy presents itself with the ordinary characters, sometimes diffused and infiltrating the whole organ, sometimes circumscribed and presenting itself under the form of more or less numerous foci situated in the neighborhood of the pleura or in the midst of the parenchyma proper.

In regard to the cerebral lesions causing the pulmonary apoplexy, we notice the following:

They were on the left side. In the first two cases the corpus striatum was torn from before backwards, and the effusion had penetrated the corresponding lateral ventricle, and in one the fourth ventricle also. In the third case there was a meningeal hemorrhage resting on the occipital and parietal faces of the left hemisphere, reaching to the fissure of Sylvius, and the convolutions were effaced.

Of these lesions two peculiarities are noticeable: first, that the apoplectic centre was considerable, and consequently could exert compression on the base of the brain; and, second, that the blood had penetrated under the arachnoid and between the vascular and nervous layers of the pia mater, and on one occasion filled the great cavity of the arachnoid itself. These two conditions appear to me as having great importance in the production of the unilateral pulmonary congestion or apoplexy; inasmuch as in numerous cases that I have observed of cerebral hemorrhage where the lesion was small and deeply situated, I have found but visceral or subcutaneous ecchymoses, and never generalized congestion or true pulmonary apoplexy. It is also probable that other affections of the brain, such as softening or tumors, in *certain conditions of seat and extent*, can produce a strong congestion or true apoplexy of the lung on the opposite side (Fleischman).

Pulmonary congestion and apoplexy of cerebral origin can be rapidly developed and follow an attack of apoplexy. In the first case, dulness was elicited nine or ten hours after the attack, and in the second, dulness and subcrepitant râles were heard the morning following the attack. In these cases, death occurred between two and fourteen days, in consequence of the brain-lesion.

Section II.—We will see now the relative influence of cerebral lesions in the production of hemorrhage, especially in the lungs of the paralyzed side.

It has long been known that section of the pneumogastric, in animals, is followed by bloody effusions in the lungs. Brown-Séquard has also shown the almost constant occurrence of visceral hemorrhage following lesions of certain parts of the base of the brain and of the brain itself. These hemorrhages occur more commonly in the lungs.

Brown-Séquard admits that the rupture of the blood-vessels that originate these hemorrhages is due either to a simultaneous contraction of the veins and arteries, forcing the blood into the capillaries and causing their over-distention and rupture, or, less probably, has been effected by the contraction of the venules alone. Be this as it may, Brown-Séquard thinks that the rupture of the capillaries is due to the irritation of the nerves of the blood-vessels following lesions of the pons Varolii and other parts at the base of the brain. Now to another question on which physiologists are divided:

What is the course followed by the vaso-motor nerves that, starting from the affected point in the brain, go to the lung in which the hemorrhage is produced? Mr. Schiff and Brown-Séquard maintained that these nerves descended with filaments of the pneumogastric; but the latter physiologist has recently shown that after section of the par vagum and irritation of the central ends, pulmonary hemorrhage is produced, while nothing like it occurs if the peripheric ends are excited. He has concluded, then, that the vaso-motor nerves of the lungs, heart, etc., pass through the cervical medulla and the first thoracic ganglion. Moreover, he maintains that the vaso-motor nerves of the thoracic and abdominal viscera do not come from the medulla oblongata, as generally thought, but from the pons Varolii and parts that surround it. It will be seen, then, that the existence of this variety of pulmonary apoplexy that I have studied is demonstrated by clinical observation and physiological experiments, the two fundamental bases of pathology.

PHILADELPHIA

MEDICAL TIMES.

A WEEKLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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EDITORIAL.

ANNOUNCEMENT.

THE last issue completed the third year of the PHILADELPHIA MEDICAL TIMES. The editors hesitate to make any promises for the coming year, knowing how often arrangements apparently effected fail in their accomplishment: it seems, however, proper to state that original communications are promised by leading physicians in London and Edinburgh; that the staff of American contributors has increased; that a competent physician has gone to Paris to report clinical lectures by professors of l'École de Médecine, and to furnish notes of the doings of the various societies and of the hospital practice; that the London letter will appear regularly; that a correspondence is promised from Vienna; and that at home the practice of the New York and Philadelphia hospitals will be reported.

This journal was not inaugurated for the purpose of making money, but was the outcome of a need felt by the medical profession. Born of the profession, it should be maintained in the interest of the profession. We are profoundly convinced that, given a sufficiently large subscription-list, it can be made to take rank with any journal of its class in the world; and as the income increases the publishers promise to increase the size of the journal, or in other way expend upon it moneys received. We pay for *all* original papers deemed worthy of publication, and for contributions of especial value we will continue, as we have done in the past, to pay especial rates.

YELLOW FEVER.

ALL of our readers have of course heard of the frightful epidemic of yellow fever which has depopulated the little city of Shreveport, driving away one-half of its population and killing ten per cent. of the remainder. Like most other similar visitations, this one is the result of a total neglect of all sanitary rules. Shreveport is the second city of Louisiana,—the great trade centre of the Red River country, so famous for its cotton and sugar,—and is estimated to have a population of from 10,000 to 13,000. It is on the Red River, at the head of steamboat-navigation, and fifteen miles below the great Red River raft, which is one of the most remarkable formations in the world, being a mass of logs and drift-wood over forty miles long, and entirely choking up the great stream, which is over twelve hundred miles long, or, including the South Fork, twenty-one hundred. This raft turns the water of the river over the adjacent country, forming great bayous, through which, at high water, steamboats pass around the raft; and it is now being blasted away by the general government.

The city is on a bluff at the river-bank, and is well situated for drainage. The whole country around is flat, and for miles and miles there is one continuous succession of marshes, swamps, and bayous. Though at low water a great surface is exposed to the action of the sun, making the surrounding country subject to malarial influences in the hot season, still the health of the city has generally been good; but this is the third time it has been visited somewhat severely by the yellow fever, the first time having been in 1853, and the second in 1867. It seems that, owing to the contending factions which have reduced the government of Louisiana to chaos, and which would have brought about a Mexican-like civil war had it not been for the strong arm of the federal government, Shreveport has been for some months without a regular municipal government. Those having control of the city have been utterly negligent of their duty, and have left the streets in an indescribably filthy condition. Under the hot semi-tropical sun, the reeking heaps of garbage, the swollen, bursting carcasses of all sorts of animals, the stagnant pools full of all uncleanness, have become the resting-place of the poison. Filth and exposure begot recklessness, and recently a most extraordinary attraction was added to the already too pressing invitation to epidemic disease. It is said (*Vicksburg Herald*) that a boat, having on board a hundred or more Texas cattle, recently sank in the Red River, very near to

Shreveport, and the dead animals were fished from the wreck and taken ashore. After having been skinned for their hides, the bloated bodies were permitted to remain exposed to the rays of a burning sun, until they poisoned the air with their sickening effluvia. Under these circumstances, is it a wonder that another tale of sorrow and desolation, another frightful warning, has been added to the long list, which should teach the world, if it would only learn, the importance of sanitary science?

AS most of our readers no doubt know, some years since there was inaugurated by law in the province of Ontario, Canada, a general medical board or council, before which all persons desirous of practising medicine in the province had to appear and undergo an examination. This licensing board has always reminded us of Barnum's happy family, since upon it regulars, homœopaths, and eclectics sit in sweet accord. Strict written and oral examinations have been enforced by this board, the candidate passing first upon those branches supposably common to the three schools, and then being examined in therapeutics according to his wishes as to his future practice.

However strange and repulsive this mixture of Jew and Gentile, of science and impudence or insanity, may appear, the process prescribed by the law really seems to have wrought great good. The compulsory study of a scientific groundwork, the side-by-side contrast of truth and falsity, have had such marked results that during the last nine years not a single homœopathist or eclectic has passed as such in the province, so that the chief of the homœopathic division has recently withdrawn from the council, and is seeking the repeal of the law under which it was created.

IN a discussion before the Medical Society of the County of Kings, New York, reported in *The Sanitarian* for October, Dr. A. N. Bell remarked,—

"He knew of but one antidote to the reproduction of fungi, and that was fungi. Naturalists tell us that the 'fairy rings' of the prairies are caused by fungi, and in this wise: they attack and destroy the grass at a central point, spreading out on all sides, leaving the ground bare. After a time, when the fungi have totally disappeared from the point first attacked, grass seeds again take root, and, spreading outwards from the centre towards the expanding border, form the ring. And the singular feature is, that the same place is not again subject to attack: the fungi have poisoned against themselves.

"This natural history of the fungi in the prairies bears a singularly interesting analogy to the results of certain zymotic diseases. They poison against themselves; and whether this peculiarity is due to the nature of the germ or not—and that it is a fungus he would not undertake to say—one thing, at least, is certain, it acts very much like it."

The fact asserted by Dr. Bell is very curious, and we would like to know upon whose observation it rests,—how a given spot was marked, and how long it was watched. Indeed, at present the statement cannot be accepted as true in its fullest extent. It may, however, be acknowledged that the fungi will not grow for some time on the ground which they have gone over; but that this is due to their poisoning against themselves seems a most unwarrantable conclusion. Fungi feed on organic matter; certain species affect certain forms of organic matter. The fairy fungus eats up its peculiar food, and the soil, being exhausted, is no longer able to sustain the parasite. No doubt if the soil be allowed to rest long enough in its wild uncultivated state, it will recover itself. At least, so we reason.

THE effect of custom in affecting our sensibilities is a strange thing. With us it is considered *infra dig.* to contract for medical services to families at so much a week, month, or year, whilst to receive a fixed fee per visit is completely *en règle.* In India things are contrariwise; and concerning the proposition to have regular fees, so much a visit, the *Indian Medical Gazette* editorially discourses as follows:

"We have received a circular from a brother officer, in which he proposes to supersede the time-honored contract system by a scale of fees per visit, arranged according to salaries. This would necessitate the keeping of accounts and the submitting of bills. There seems to be but one step between this sort of thing and the shop,—the lowest form of medical practice. It would be demoralizing in the extreme to associate every particular act of attendance or service on the part of the doctor with a sum of money, in most cases trifling; and nothing could be more humiliating than the necessity of annually, or at the end of a protracted attendance, presenting a grateful patient or sorrowing relative with something like the following:

JOHN JONES, JOINT MAGISTRATE OF STINKABAD, Dr.

TO SURGEON-MAJOR PHILIP GRAB,
Civil Surgeon of Stinkabad,

	Rs.	As.	P.
To 25 visits, @ Rs. 5	125	0	0
" 5 night do., @ Rs. 10	50	0	0
Total	175	0	0

E. & O. E.

Received payment,

P. GRAB.

"Nothing would more effectually smother the nice feeling which ought to exist between a doctor and his patient than this sort of thing; a medical man would even feel a delicacy in paying a second visit to a sick person, however necessary he might consider it, unless specially sent for."

IT is stated that the tops of the Ornithogallum pyrenaicum have come largely into use at Bath, England, as a substitute for asparagus.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, SEPTEMBER 11, 1873.

THE PRESIDENT, DR. J. H. HUTCHINSON, in the chair.

DR. W. G. PORTER exhibited for Dr. Milner the *urethra, ruptured bladder, ureters, and kidneys* of a dog. The dog was brought to Dr. M. with apparent retention of urine. A post-mortem examination revealed a calculus in the urethra, which had so effectually occluded the canal that the accumulation of urine finally caused a rupture of the bladder. The stone was lost.

Dr. JAMES TYSON presented a specimen of *aneurism of the abdominal aorta* from Geo. W. E., aged about 50 years, who was admitted to the Philadelphia Hospital in the latter part of August, complaining of pain in the left lumbar region, which, however, received little attention, as the man was thought to exaggerate his suffering. He therefore obtained little sympathy. He said he had had syphilis many years ago, and attributed all his suffering to this cause.

His complaint continuing, a physical exploration of his abdomen revealed dulness throughout the left hypochondriac and lumbar regions. A cystic kidney was thought of, and the urine was carefully examined, but found free from pus or albumen.

On the 1st of September a more careful physical exploration was made, when it was found that dulness began laterally at the sixth rib and extended to the crest of the ilium. The axilla above the sixth rib was normally resonant. The epigastric region on light percussion was tympanitic; to a forcible blow there was dulness. The dulness of the left lumbar region extended to the median line. The iliac region responded normally to percussion. Posteriorly, percussion was dull from the spine of the left scapula to the crest of the left ilium. In the infra-spinous fossa there was bronchial breathing; below the scapula the respiratory murmur was feeble, and vocal fremitus was almost absent, also laterally below the sixth rib.

The patient now had a very frequent, feeble, and irregular pulse, but his skin was warm, and there were no symptoms of collapse. He complained of pain throughout the area of dulness, but could sit up without any difficulty or distress in breathing. No impulse was at any time observed, and auscultation of the abdomen was not thought of.

On September 3, the left half of the abdomen and the lower third of the thorax were much swollen, the point of culmination appearing to be in the vicinity of the floating ribs. This area was hard, flat on percussion, and purplish in hue. The patient was now evidently in collapse, and died at five o'clock this day, the last examination having been made about noon.

The post-mortem examination was made fifteen hours after death. The region alluded to in the last note as the seat of dulness and hardness had become soft, and the intercostal spaces, which were almost obliterated, were then distinct. On making the abdominal section, the space between the muscles and fascia was found infiltrated with blood. On laying back the abdominal walls upon the left side, this infiltration was noticed forming a clotted mass in the situation of the abdominal walls over the left iliac fossa. There was also observed a tumor occupying the left hypochondriac and upper part of the left iliac region, encroaching somewhat upon the thoracic space, so that the lower edge of the left lung corresponded with the fifth interspace. To the left side of the tumor was attached the descending colon. On the upper and outer surface lay the spleen, which was of normal size and consistence; on the antero-lateral surface of the tumor lay the left kidney, much enlarged, measuring five inches in its longer diameter and two and a half in its width.

Further exploration revealed this tumor to be a huge clot beneath the peritoneum, continuous at its upper portion with an opening in an aneurism of the aorta below the diaphragm. The sac was four inches in diameter, and lined with plates of calcareous matter. Anteriorly from the aneurism protruded a prominence which resembled the head of the pancreas and was perforated by a blood-vessel of considerable size. This, on section, proved to be an organized clot made up of numerous concentric layers of fibrin, by which the anterior wall of the vessel was greatly strengthened, rendering rupture in this situation impossible. The aneurism was therefore compelled to yield at a weaker point, which was on its left inferior aspect. The firmness of the large clot led the doctor to believe that the hemorrhage had ceased for a time; that is, the clot had closed the orifice of rupture, after which the man lived in the feeble but not collapsed state alluded to as present two days before death. A yielding of the clot finally permitted the hemorrhage which caused his death, and which produced the liquid infiltration and mass of semi-liquid or imperfectly coagulated blood in the abdominal wall between the muscles and peritoneum and over the left iliac fossa. There was caries of the bodies of the lumbar vertebræ.

Dr. C. B. NANCREDE referred to a case of aneurism of the abdominal aorta in which there had been profuse diuresis, and desired to know whether it was present in this instance. Dr. TYSON replied that none had been observed.

Dr. ALLIS referred to an autopsy at which he was present. The case presented during life a solid tumor extending from the diaphragm to the pelvis and lying on the left side of the vertebral column. It was attended with excruciating pain, and the relief the patient experienced from morphia was so complete that he was suspected of malingering. The case was under observation for about a month, and abscess of some deep structure was suspected. No suspicion of aneurism was entertained.

Dr. ALLIS did not see the case during life, and would ask the Society what effect aneurism of the abdominal aorta would have upon the pulsation in the femoral arteries.

The PRESIDENT said that a *retarded beat* in the femoral was expected in affections of this kind.

Dr. WHARTON SINKLER exhibited a specimen of *aneurism of the ascending aorta*, from J. G., colored, æt. 66 years, married, and of temperate habits. He was by occupation a coachman, but for twenty years had had no regular employment, and had done light work of any kind. In 1848 he sustained a compound frac-

ture of the leg, and was in the Pennsylvania Hospital a year, at the end of which time the leg was amputated just below the knee. The stump healed rapidly, and has never given any trouble. With the above exception, he had always enjoyed good health. Never had acute rheumatism, but had occasionally pain in the shoulder or knee.

Two years ago, he began to have slight attacks of dyspnœa on exertion; had no palpitation of the heart or other symptom of disease of that organ. Had never had precordial pain.

About one year ago, he had a violent and alarming attack of dyspnœa. Stimulants and a hypodermic injection of morphia very promptly relieved the symptoms, and for several months the patient enjoyed good health, with the exception of occasional paroxysms of dyspnœa.

A physical examination revealed a loud blowing murmur at the base of the heart, coincident with systole. The murmur was transmitted along the course of the aorta and the carotids. There was no visible pulsation of the superficial arteries. Urine was scanty, and contained about one-third albumen. No microscopical examination was made.

About the beginning of April, 1873, a pulsating tumor, about the size of a pigeon's egg, was observed just above the sternal end of the left clavicle. There was no thrill distinguishable in it, but on placing the stethoscope over the swelling the aortic murmur was distinctly heard. The tumor increased gradually in size, and finally the clavicle was elevated by it to a marked degree. There was no dysphagia or aphonia.

On May 19, sphygmographic tracings were taken of the right and left radials. There was a modification in the trace of both radials, but the right indicated a more oblique line of ascent and a more rounded apex-curve.

During the last five months of his life there were general anasarca and some peritoneal effusion. There was also some œdema of the lungs.

Diuretics and purgatives were used, but without relief to the dropsy, and the patient gradually became weaker, and died August 20, 1873.

Post-mortem, thirty-two hours after death.—Rigor mortis marked. Considerable deposit of fat in superficial fascia. Cartilages of ribs ossified. Pleural and abdominal cavities contained a moderate quantity of fluid. Lungs congested. Heart dilated and walls thin. Pericardium adherent to heart throughout, but easily detached. No disease of valves, except a slight thickening of the aortic valves.

Arch of aorta enlarged to double its usual size. Its inner surface was roughened, and covered with patches of atheroma and calcareous plates. The innominate artery was greatly enlarged, the dilatation extending to the carotid and subclavian for about two inches.

The left carotid and subclavian arteries were not materially increased in size. The kidneys were small, but did not appear diseased.

Dr. C. H. BURNETT presented a bean from the honey locust-tree, removed from the ear of a boy æt. 13 years. There was every reason to believe it had been introduced two years ago. The boy consulted him not with regard to this ear, but for some pain in the other; and it was only on examining the ear for another purpose that he discovered the foreign body. It was removed without any difficulty. Indeed, Dr. Burnett had never met any difficulty in removing foreign bodies from the ear when they had not been previously manipulated by the laity or sometimes by medical men.

The bean was in a perfect state of preservation, and the boy said he had been induced to introduce it from having seen the same thing done by older boys, who pretended to remove the foreign body through the nose.

TWENTY-FIRST ANNUAL MEETING OF THE AMERICAN PHARMACEUTICAL ASSOCIATION.

HELD AT RICHMOND, VIRGINIA, SEPTEMBER 16, 1873.

Reported by ADOLPH W. MILLER, M.D.

PRESUMING that the transactions of this body, which bears so close a relation to the medical profession, may be of interest to some of your readers, I venture to offer the following epitome of the proceedings, which have just been brought to a highly successful termination. The attendance of members at this, the first meeting of the Association in a Southern city, was larger than usual. All the deliberations were carried on in a very orderly, decorous, and business-like manner, and they were attentively listened to by the assembled pharmacists, many of whom were accompanied by their ladies.

The meeting was called to order on Tuesday, the 16th ult., at three o'clock, by President Albert E. Ebert, of Chicago, Illinois. He stated in his introductory remarks that at the same moment the Austrian Apothecaries' Association was in session in Vienna, and the British Pharmaceutical Conference at Bradford, England, from the latter of which he read a telegram of hearty greeting, to which he had replied as follows: "We return your fraternal greetings."

The mayor of the city of Richmond, A. M. Keiley, Esq., was then introduced to the audience. He congratulated the Association on its having attained its majority in that city, and proposed that its members be naturalized and remain evermore citizens of the Old Dominion. In concluding his happy and very appropriate address, which was received throughout with cheers, he dwelt on the good taste shown by the visitors in bringing with them the fair representatives of their hearths.

The important event of the second session, on Wednesday morning, was the election of officers for the ensuing year, resulting as follows:

President,—John F. Hancock, Baltimore.

First Vice-President,—William Saunders, London, Ontario.

Second Vice-President,—John F. Buck, Jackson, Mississippi.

Third Vice-President,—Paul Balluff, New York.

Treasurer,—Charles A. Tufts, Dover, New Hampshire.

Permanent Secretary,—John M. Maisch, Philadelphia.

Reporter on the Progress of Pharmacy,—C. Lewis Diehl, Louisville, Kentucky.

The Standing Committees on the Drug Market, on Papers and Queries, on Business, on Unofficinal Formulas, on Legislation, on Liquor-Dealers' License, on Stamp Tax, and on the Meeting in 1876, were also confirmed; after which the treasurer made his report, showing a balance of $982.77 on hand.

Professor Ebert, of Chicago, had in store a very agreeable surprise, consisting in a donation of five hundred dollars to the Association. In the modest note accompanying his munificent gift, he desired the annual interest of the fund to be devoted to procuring a suitable prize for the best essay containing original investigation of a medicinal substance, determining new properties, or containing other meritorious contributions to knowledge. Thanks befitting the occasion were offered to the donor, and it was at once decided to designate the present as the Ebert Fund, and its interest as the *Ebert Prize*.

Prof. Diehl presented a report detailing a plan for an international pharmaceutical congress, to be held in Philadelphia in 1876.

A number of valuable papers were read in the course of the morning. Among them were several of more

than usual interest, by Dr. Squibb,—one of these a new style of physicians' pocket-cases, whose peculiarity consists in being furnished with an accurately graduated minim pipette, which can be dipped into each of the vials, thus materially facilitating the administration of small doses of powerful remedies. The cases are made of different sizes, some of them being furnished with clasps, while others are arranged as slides. Obstetrical cases for fluid extracts of ergot and veratrum viride and denarcotized tincture of opium, with measuring pipette, were also shown, and it was stated that these are very popular in New York City.

Prof. G. F. H. Markoe, of Boston, read a lengthy review of the United States Pharmacopœia of 1870, in which he called attention to a number of inaccuracies, and severely criticised some of the processes. He particularly deprecated the plan of making so many of the fluid extracts by a set schedule, and desired a separate formula for each of them.

The morning was chiefly occupied with the reading of scientific papers, one of the most important being the official report of Prof. Hancock on the unofficinal elixirs. His paper was accompanied by some very elegant specimens of his elixirs, for all of which he gave succinct and readily executed formulæ.

Prof. Maisch then offered a resolution recommending that these formulæ be used by the members of the Association, and that a printed copy be sent to the medical societies of the Union, with a request that physicians, when prescribing elixirs, would give preference to these.

Prof. Maisch showed some muriate of cinchonia which had been sold to Mr. G. I. Luhn, of Charleston, South Carolina, as sulphate of quinia, by a notorious New York firm: it had been put up in imitation of imported French quinia, and was sold a trifle below the price of the domestic article.

A resolution tendering the hearty thanks of the Association to the pharmacists and citizens of Richmond, for the cordiality of the reception at this its first visit to the Sunny South, preceded the final adjournment.

Pharmaceutical Exposition.—Perhaps the most inviting and instructive feature of the meeting was the exhibition of drugs, chemicals, apparatus, and other objects of interest to pharmacists. Of the many interesting objects space is wanting to notice more than a few.

As usual on similar occasions, the finest and largest collection of choice chemicals was exhibited by the renowned Philadelphia firm, Messrs. Powers & Weightman. One of their bell-glasses contained about $1300 worth of morphia, and another about $800 worth of quinia, the entire value being nearly $5000. Rosengarten & Sons presented a good assortment of fine chemicals, also a handsome specimen of cultivated cinchona-bark from the government gardens at Ootacamund in India.

Charles T. White & Co., of New York, made an elaborate display of raw chemicals; they make a specialty of resublimed carbonate of ammonia, and very pure acetic acid, which enable druggists to furnish the liquor ammonii acetatis entirely free from empyreumatic taste.

Lazell, Marsh & Gardiner, of New York, displayed true Pareira brava, agreeing with the description recently published in the English journals; Austrian rhubarb from Rheum Rhaponticum, which has lately been rejected by the New York Custom-House; Persian opium, a new sophistication, being an extract made of the entire poppy capsule.

Hance Bros. & White, of Philadelphia, made decidedly the finest and most ornamental display in the room. Their very numerous preparations were elegantly put up in engraved bottles, mounted on a beautiful black-walnut stand.

Ira W. Blunt, of Richmond, Virginia, was almost constantly on hand to explain the merits of Valentine's meat-juice. The superiority of the domestic meat-extract is claimed to be due to the low temperature used in its evaporation, which never exceeds 130°, so that the albumen is not coagulated, but is retained in its natural state.

Dr. James B. McCarthy, of Richmond, offered seven specimens of native wines made at his vineyards in Henrico County, each of them accompanied by the grapes from which it is manufactured. These wines, being perfectly pure, having a pleasant taste, and being offered at comparatively low prices, deserve a favorable recognition by the profession.

Good, Roof & Co., of New York, exhibited elixir de Vichy, imported from France. This claims to be prepared by concentrating Vichy-water and then flavoring with an aromatic cordial.

S. Mason McCollin, of Philadelphia, showed watch-spring pessaries made in an improved manner by the Breed process.

Oscar G. Crosby, of Richmond, Virginia, had on exhibition a model of an improved invalid's bedstead, invented by himself. It is furnished with a crank for elevating the upper half of the bottom to any desired angle, at which it can be kept stationary; also a crank for lowering the mattress without disturbing the patient, and one for moving and fixing the foot-rest to wherever it may be most convenient. There is an additional arrangement for lowering the lower half, so that the whole bedstead becomes converted into a reclining chair. It is apparently a very useful, and certainly is a highly ingenious, invention, though, like many similarly complicated appliances, it may possibly soon get out of order.

REVIEWS AND BOOK NOTICES.

SMALLPOX, FROM AN EPIDEMIOLOGICAL AND PROPHYLACTIC STAND-POINT. By DR. LEON COLIN, Physician-in-Chief of the Military Smallpox Hospital of Bicêtre during the Siege of Paris, 1870–1871, etc., etc. (La Variole au Point de Vue épidémiologique et prophylactique. Par LEON COLIN, Médecin principal de l'Armée, Professeur à l'Ecole d'Application de Médecine militaire (Val de Grâce), Médecin-en-chef de l'Hôpital militaire des Varioleux de Bicêtre pendant le Siége de Paris, 1870–1871. Paris, J. B. Baillière et Fils, 1873, pp. 158.)

In this well-written monograph Prof. Colin gives us the results of his experience in the epidemic of smallpox which prevailed so extensively in Paris at the time of the German invasion of France; and, as the field of observation was, unfortunately, very ample, comprising nearly eight thousand cases and over one thousand deaths in a period of about six months, the conclusions at which he arrived are eminently valuable.

As it would be impossible to reproduce these, however, in the short space allotted for this notice, we will content ourselves with mentioning that in regard to animal vaccination, of late so warmly discussed, Dr. Colin states that out of one hundred and twenty of the hospital attendants vaccinated in his presence, from a heifer, not one contracted smallpox, although living so constantly in the atmosphere of contagion; and in reference to the isolation of smallpox cases, Dr. Colin asserts that in spite of the overflowing condition of the wards of Bicêtre, where twelve hundred variolous patients were crowded together for several months, no perceptible aggravation of the disease in consequence of the accumulation of poisonous emanations in the circumambient air could at any time be detected.

THE EFFECTS OF HIGH ATMOSPHERIC PRESSURE, INCLUDING THE CAISSON DISEASE. By ANDREW H. SMITH, M.D., Surgeon to the New York Bridge Company, Member of the Academy of Natural Sciences, Philadelphia, etc., etc. Being the Prize Essay of the Alumni Association of the College of Physicians and Surgeons. New York, 1873, pp. 53.

However true, as a general rule, may be King Solomon's assertion that "there is no new thing under the sun," we certainly seem to have, in the subject of this memoir, a novel malady, which former ages never inflicted upon mankind. From the "caisson," this Pandora's box of the nineteenth century, appears to have issued, to quote Dr. Smith's definition of the complaint which he has the honor of naming, "a disease depending upon atmospheric pressure, but always developed after the pressure is removed. It is characterized by extreme pain in one or more of the extremities, and sometimes in the trunk, and which may or may not be associated with epigastric pain and vomiting. In some cases the pain is accompanied by paralysis more or less complete, which may be general or local, but is more frequently confined to the lower half of the body. Cerebral symptoms, such as headache and vomiting, are sometimes present. The above symptoms are connected, at least in the fatal cases, with congestion of the brain and spinal cord, often resulting in serous or sanguineous effusion, and with congestion of most of the abdominal viscera."

In the treatment of these cases, whereof thirty are recorded, Dr. Smith relied chiefly on morphia and atropia, by the mouth or hypodermically, and the administration of Squibb's fluid extract of ergot in teaspoonful doses. Some judicious suggestions in regard to prophylaxia conclude the report.

A MANUAL OF MEDICAL JURISPRUDENCE. By ALFRED SWAINE TAYLOR, M.D., Fellow of the Royal College of Physicians, and Professor of Medical Jurisprudence and Chemistry in Guy's Hospital. Seventh American Edition. By JOHN J. REESE, Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania.

Every system of morals inculcates respect for gray hairs; and when a book has reached the hoary age of the seventh edition, let the critic fondle it lovingly if he like, but let him beware how he raise an irreverent hand against the work anointed by the profession. In the presence of the general verdict, we deem it best to keep silence, and merely in a few words inform our anxious readers what has happened to their favorite in this its sixth regeneration. Well, the high priest of the ceremonial has been Prof. Reese, and he appears to have done his work judiciously,—we may say lovingly. To aid him he has had the advanced sheets of the still parturient London edition of the author's great work on the Principles and Practice of Medical Jurisprudence, and has availed himself of it by incorporating much new matter from it into the text of his bantling. Several subjects not treated of in the former edition are discussed in this one; and we doubt not that the work will continue to enjoy the sunshine of success and of professional favor.

NATURE IN DELIRIUM TREMENS.—Dr. Van de Warker believes (*New York Medical Journal*, August, 1873) that opiates, stimulants, and narcotics generally do harm in the treatment of delirium tremens, and that the proper plan is to provide for the nutrition of the impoverished brain and nerve-centres, by the free administration of food which can be easily digested and assimilated. Beef-tea, raw eggs, and milk, with attention to the condition of the bowels, have given him very satisfactory results.

GLEANINGS FROM OUR EXCHANGES.

WOUND OF THE LIVER (*Chicago Medical Journal*, September, 1873).—Dr. G. W. Stewart reports the case of a farmer's boy, æt. 17, who was knocked down by a runaway team in front of his plough, the point of which struck him in the back. It inflicted a wound eleven inches in length, extending from the fourth to the first lumbar vertebra, in the left hypochondriac region, engaging the twelfth rib and denuding it of its periosteum in the anterior third, passing through the peritoneum, entering the liver at the left lateral ligament and proceeding in the direction of the intersection of the longitudinal with the transverse fossa, within which, and only a few lines beyond the terminus of the incision, could be distinctly felt the hepatic artery. Nearly or quite all of that portion of the left lobe of the liver anterior to the incision was found protruding through the wound. The case was seen about two hours after the accident; hemorrhage had ceased, but the patient was nearly comatose from want of blood, a large quantity of which was removed from the abdominal cavity with a sponge: the stomach was empty and had escaped injury, as had also the intestines, diaphragm, and other organs. The abdominal aorta could be distinctly felt in the floor of the wound.

The protruding portion of the liver was replaced with some difficulty, and retained by a compress and a wide roller bandage; cold water was applied to the wound, which was closed up, the patient was placed on a bland and restricted diet, and small doses of opiates were administered. The compress was removed at the end of twenty-four hours, but no other change was made for some time. The wound began to discharge pus freely about the sixth day, the patient gained strength from the first, and no indications of peritonitis appeared at any period. About the twelfth day the flaps sloughed off and exposed to view the liver and also the twelfth rib. A portion of the former equal in size to a two-inch cube was again protruding through the wound, and was irreducible, owing to adhesions between the borders of the left lobe and the abdominal wall. Caustic was applied daily, and the cauterized material afterwards removed with a knife, until the prominence had disappeared. About one-half of the exposed and projecting rib was then removed with bone-forceps. The wound then improved in condition, the two fragments of liver united perfectly, the cauterized surface healed speedily, granulations sprang up rapidly in the muscular tissue and continued until the divided muscles were reunited and integument formed over the entire surface. The case terminated in complete recovery in about seventy days.

GASTROTOMY FOR INTESTINAL OCCLUSION.—Dr. Samuel Whitall, in an interesting and elaborate paper on the above subject, gives a history of the operation from the earliest days down to the present time, and discusses at length its feasibility, the modes of its performance, the objections which are urged against it, and the beneficial results which are to be hoped for from it.

He details, classifies, and tabulates thirty cases of operation, and finds that when the conditions were as favorable as one could reasonably expect in a disease of such great fatality—*i. e.*, when there existed no serious abdominal obstacle, such as extensive peritonitis, gangrene, perforation, insuperable occlusion, etc.—"*one hundred per cent. were saved, whereas without such interference every one of these must unquestionably have died.*"

He says the term *gastrotomy* is an unfortunate one, and had better be restricted to the operation of opening the stomach, *laparotomy* more accurately expressing simple abdominal section. "The term *gastrotomy* (or

laparotomy) in its present connection is applied to a large incision made through the abdominal walls for the purpose of searching for, and, if possible, of relieving, internal intestinal obstruction. If after laying open the abdominal cavity the operator should open the intestine, whether he intend to sew it up again and return it into the peritoneal cavity, or to establish an artificial anus, the operation receives the name of *gastro-enterotomy*. *Enterotomy* is applied to the operation which has for its object the establishment of an artificial anus, whatever may be the process employed or the seat of the operation."

In reply to the query, What can be accomplished by the operation? he answers—1. The restoration of the patient to perfect health by the complete removal of the obstruction without opening the intestinal canal.

2. In cases of intramural occlusion, it enables the operator to discover its exact locality, and after having removed the obstacle he can sew up the bowel and return it into the abdominal cavity, or establish an artificial anus, as circumstances require.

3. Should the seat of the obstruction not be discovered, it enables the surgeon to form an artificial anus as near as possible to the affected point, in the hope that, the intestinal tension being thus relieved, the passage would become clear and the artificial opening subsequently close.

4. The seat of the obstruction being recognized but found to be insuperable, it enables the operator, by the formation of an artificial anus, greatly to relieve the patient's sufferings, in mitigating the pangs of unavoidable death.

This paper was written by Dr. Whitall apropos of the death of Dr. Tyce, of New York City, in whose case he believes gastrotomy would not only have been justifiable, but would have been of incalculable benefit.—*New York Medical Journal*, August, 1873.

ITCH IN THE LEOPARD.—Dr. Theodor Simon, of Hamburg, records, in the *Archiv für Dermatologie und Syphilis*, No. 1, 1873, a case of scabies in the leopard, which came under his notice. The animal was an old member of the Zoological Garden collection, and crusts upon various parts of his body had been noticed for some time previous. The leopard was examined and some of the crusts were taken from his head, and under the microscope showed epidermic scales, blood-corpuscles, and numerous itch-mites, together with their excrement and eggs. The insects were found to be of all ages, and both males and females were discovered, though the latter were greatly in excess. Upon close study, the mites were determined to be identical with the human itch-mite, or *Sarcoptes hominis*. The disease was most marked about the head and breast of the animal. In what way the scabies had been contracted could not be discovered, for the keeper in charge of the leopard, although frequently touching him, was free from any trouble of the kind. The beast was successfully cured by inunctions of balsam of Peru, which were made, not without difficulty, by the keeper. Some time after, the leopard died suddenly, and the examination of the body showed no trace of the former scabies.

ACUTE ANÆMIA DUE TO FRIGHT.—An interesting case presented itself at St. Bartholomew's Hospital, in the person of a young woman, æt. 20, pallid, bleached, not menstruating, and with the typical aspect of an anæmic female. She stated that ten weeks previously she was in perfect health, had a good color, and menstruated regularly. At that time a fire had broken out in a house adjoining that in which she lived, and she had been exceedingly alarmed. Since then her menses had ceased and she had assumed her present appearance.

There can be no doubt that anæmia is too frequently regarded and treated as the result of a constant blood-defect—the consequence of a chemically altered circulating fluid. Such cases direct attention to a deeper and more significant pathogeny for some forms of anæmia,—an altered condition of the nervous system. *British Medical Journal*, Aug. 23, 1873.

ATROPIA IN CHOLERA.—During a recent outbreak of cholera, Dr. R. Saunders obtained excellent results by the hypodermic injection of one-fiftieth to one-thirtieth of a grain of sulphate of atropia. In some cases the relief afforded was astonishing: the more distressing symptoms—vomiting, purging, and cramps—were ameliorated almost at once; the skin grew warm, the pulse rose, the surface, previously clammy and shrivelled, assumed its natural condition, and in some instances the patient slept soundly for ten or twelve hours, the bowels remaining undisturbed during the entire time. These effects, however, only followed when the atropia was used in sufficient quantities to produce the specific scarlatina rash, dry throat, and dilatation of the pupils.—*The American Practitioner*, July, 1873.

MORPHIA IN ACUTE URÆMIA.—Dr. Alfred Loomis asserts that morphia can be administered hypodermically to some, if not to all, patients with acute uræmia, its almost uniform effects being—1, to arrest muscular spasms by counteracting the effect of the uræmic poison on the nerve-centres; 2, to establish profuse diaphoresis; 3, to facilitate the action of cathartics and diuretics, especially the diuretic action of digitalis. It must be given in sufficient quantities to control convulsions, as neither the contraction of the pupils nor the number of respirations is a reliable guide in its administration.—*New York Medical Record*.

MISCELLANY.

CULTIVATION OF IPECACUANHA.—Dr. G. Henderson, in his report on the Royal Botanical Gardens, Calcutta, published in the *Calcutta Gazette* of June 25, describes the progress which has been made in the cultivation of ipecacuanha. There are now about seven thousand plants either at Rungbee or Calcutta, and no difficulty appears to exist in propagating the plant artificially. The conditions under which it will flourish in the open air have not been as yet determined. Experiments are, however, being made in this direction. Dr. Henderson has also tried to cultivate the Exogonium purga, which yields the jalap of commerce, but as yet without success.—*Indian Medical Gazette*.

DR. M. DE CHRISTOFORIS and Dr. Zambeletti, of Milan, announce that their proposal for the study and initiation of a universal pharmacopœia has been accepted by the Executive Committee of the Viennese Medical Conference, and will be brought into public discussion.—*Medical and Surgical Reporter*.

STREET-ACCIDENTS IN LONDON.—These injuries, of which only 1334 were reported in 1866, increased steadily to 1919 in 1870, leaped up to 2445 in 1871, and were 2677 in 1872. Altogether, since 1866 there have been 771 persons killed in the streets and 12,630 persons more or less injured.

CHOLERA.—According to official reports, there have been of deaths from this disease in—

Cincinnati, August 16 to 30,	11
Elmira, N.Y., for August,	1
Evansville, Ind., for four weeks ending August 24,	9
Indianapolis, for August,	40
Louisville, for week ending August 23,	2
St. Louis, for week ending August 23,	9
Wheeling, for August	4

The Sanitarian.

HOW TO SWALLOW A PILL.—*The Chicago Medical Times* is responsible for the following: "Put the pill under the tongue and behind the teeth, and let the patient immediately take a large swallow of water, and he will neither feel the pill nor taste it. In fact, he cannot tell where it has gone; and I have seen them (*sic*) look about the floor to see if they had not dropped it."

THE International Congress of Physicians at Vienna was opened on the 1st of September, by the Archduke Rainer. The subject of vaccination was the first question presented for discussion. In our next number we shall give to our readers, through our own correspondent, an account of its proceedings.

A SOLUTION of five parts of borax in one hundred of water is represented to prevent the putrefactive process in meats for considerable time. Flesh dipped in the mixture and then dried resists the usual process of decomposition.—*The Sanitarian.*

THE death of two members of one family, and the dangerous illness of the remainder, four in number, from drinking the milk of a goat which had eaten *Æthusa cynapium*, are reported to have occurred in the county of Limerick.

MR. JOHN STUART MILL has bequeathed £3000 to any one university in Great Britain or Ireland that shall be the first to open its degrees to women, and to the same university a further sum of £3000 to endow scholarships for female students exclusively.

THE Russian lady medical students have been refused permission to study medicine at the Universities of Strasburg and Giessen by the authorities of those institutions.

LIDIA RODELRENA, a wealthy Russian lady, has just presented to the St. Petersburg Academy of Medicine $40,000 to endow a department for the medical instruction of women.—*Western Lancet.*

A REAL lover of his race, in view of the approaching era of political speech-making, advertises for some secret and expeditious method of communicating lockjaw.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM SEPTEMBER 23, 1873, TO SEPTEMBER 29, 1873, INCLUSIVE.

BAILY, E. J., SURGEON.—When relieved by Surgeon Magruder, to proceed to Wilmington, Delaware, and report by letter, upon his arrival there, to the Surgeon-General. S. O. 187, c. s., A. G. O.

MCPARLIN, T. A., SURGEON.—When relieved by Surgeon Irwin, to report in person to the Commanding General, Department of the Missouri, for assignment to duty. S. O. 187, c. s., A. G. O.

MAGRUDER, D. L., SURGEON.—When relieved by Surgeon Alexander, to report in person to the Commanding Officer, Department of Arizona, for duty as Medical Director. S. O. 187, c. s., A. G. O.

PAGE, CHARLES, SURGEON.—Relieved from duty at Fort D. A. Russell, Wyoming Territory, and assigned to duty at Omaha Barracks, Nebraska. S. O. 140, Department of the Platte, September 12, 1873.

RANDOLPH, JOHN F., SURGEON.—Relieved from duty at Omaha Barracks, Nebraska, and assigned to duty at Fort D. A. Russell, Wyoming Territory. S. O. 140, c. s., Department of the Platte.

IRWIN, B. J. D., SURGEON.—To report in person to the Superintendent of the Military Academy, West Point, New York, for duty. S. O. 187, c. s., A. G. O.

ALEXANDER, C. T., SURGEON.—Assigned to duty as Attending Surgeon at St. Louis, Missouri. S. O. 187, c. s., A. G. O.

WEEDS, JAMES F., SURGEON.—Granted leave of absence for thirty days, on Surgeon's Certificate of Disability. S. O. 204, Department of Dakota, September 12, 1873.

WOLVERTON, W. D., ASSISTANT-SURGEON.—Granted leave of absence for thirty days. S. O. 186, c. s., A. G. O.

BROWN, HARVEY E., ASSISTANT-SURGEON.—Assigned to duty at Key West, Florida, as soon as his services can be dispensed with at Fort Jefferson, Florida. S. O. 148, Department of the Gulf, September 12, 1873.

RETURN OF DEATHS AND INTERMENTS IN PHILADELPHIA FROM AUGUST 30 TO SEPTEMBER 27, 1873.

DISEASES.	Adults.	Minors.	DISEASES.	Adults.	Minors.
Abscess	3	...	Erysipelas	1	1
Aneurism	...	1	Fatty Degene'n Kidneys.	1	...
" of the Aorta	1	...	Fever, Catarrhal	...	1
Apoplexy	12	...	" Congestive	...	1
Asphyxia	...	5	" Gastric	...	2
Asthma	3	1	" Remittent	1	1
Burns and Scalds	...	4	" Scarlet	...	6
Cancer	4	...	" Typhoid	19	11
" of Breast	5	...	Fracture of the Spine	2	...
" Face	1	...	Gangrene	1	2
" Liver	3	...	Gout	1	...
" Œsophagus	1	...	Hemorrhage	4	2
" Prostate	1	...	" Bowels	3	...
" Pylorus	2	...	" Lungs	3	...
" Rectum	2	...	" Nose	1	...
" Stomach	3	...	" Uterus	1	...
" Tongue	1	...	Hernia	4	...
" Uterus	4	...	Inanition	2	22
Casualties	16	6	Inflammation of Brain	8	27
Cerebro-Spinal Meningitis	1	4	" Bronchi	4	4
Cholera Infantum	...	80	" Heart	1	...
" Morbus	2	1	" Kidneys	1	...
" Sporadic	1	...	" Larynx	1	...
Cirrhosis of Liver	4	...	" Liver	2	1
Colic	...	1	" Lungs	16	11
Compression of Brain	1	...	" Peritoneum	6	1
" " Spine	1	...	" Spine	1	...
Concussion of Brain	...	1	" Stomach & Bowels	9	21
Consumption of Bowels	...	1	Intemperance	3	...
" Lungs	129	22	Intussusception	...	2
Congestion of Bowels	1	1	Jaundice	1	1
" " Brain	14	18	Laryngismus Stridulus	...	1
" " Lungs	2	6	Mania a potu	1	...
Congestive Chill	1	...	Marasmus	2	90
Convulsions	3	43	Measles	...	1
" Puerperal	2	1	Murder	2	...
Cramps	...	1	Necrosis	2	...
Croup	...	6	Neuralgia of the Heart	1	...
Cyanosis	...	5	Obstruction of Bowels	1	...
Debility	31	36	Old Age	41	...
Diarrhœa	11	7	Paralysis	10	1
Diphtheria	...	3	Poisoning	1	1
Disease of Brain	12	2	Pyæmia	4	...
" Heart	23	3	Scrofula	2	1
" Hip	...	1	Softening of Brain	3	...
" Kidneys	8	...	" Stomach	1	...
" Liver	2	1	Sore Mouth	...	2
" Stomach & Bowels	1	...	Still-Born	...	66
Dropsy	16	...	Strangulation	...	1
" of Abdomen	1	...	Suffocation	1	3
" Brain	1	6	Suicide	2	1
" Chest	1	...	Syphilis	1	1
" Heart	2	...	Tabes Mesenterica	...	4
Drowned	7	5	Teething	...	2
Dysentery	10	4	Tetanus	1	6
Effusion on Brain	...	3	Ulceration of Stomach	1	...
" Heart	1	...	Unknown	2	2
Emphysema	2	...	Wounds, Gunshot	1	1
Epilepsy	6	...			
			TOTALS	551	578